STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157579	A. BUILDING _____ B. WING _____	R-C 03/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CJ'S ABUNDANT CARE	523 W PLUM ST CHESTERFIELD, IN 46017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments This was the second revisit for a state home health agency complaint investigation survey completed December 08, 2011, with the first revisit January 20, 2012. Survey Dates: March 5, 6, and 7, 2012 Facility #: 004091 Medicaid Vendor #: 200806840 Surveyors: Susan E. Sparks, RN, PHNS, Team Leader Bridgett Boston, RN, PHNS, Team Member Kelly Hemmelgarn RN, PHNS, Supervisor Seven deficiencies were found corrected and two deficiencies were recited with this survey. Five new deficiencies were cited. Quality Review: Joyce Elder, MSN, BSN, RN March 9, 2012 This survey was modified as the result of an IDR 4/4/12. je	{N 000}		
N 416	410 IAC-17-10-1(k) LICENSURE Rule 10 Sec. 1(k) In conducting a survey, a surveyor shall receive copies of any and all documents necessary to make a determination of compliance. The surveyor may do either of the following: (1) Make copies with the permission of the home	N 416		

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N 416	Continued From page 1 health agency. (2) Supervise any copying process to ensure that photocopies are true and accurate. At the sole discretion of the department and for good cause shown, the home health agency may be granted up to twenty-four (24) hours to produce documents requested by the surveyor. This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure all of the requested documents for determination of compliance were received for 1 of 5 records reviewed (#21). Findings include: 1. Clinical record # 21 failed to evidence care was provided to the patient from February 27, 2012, through March 4, 2012. 2. On 3/6/12 at 11:45 AM, employee FF indicated the nurse visit notes for the care provided on February 27 through March 4, 2012, for patient # 21, were not available and had been placed into the mail. They expected the notes to be delivered by the United States postal service on Wednesday March 7, 2012. 3. On 3/7/12 at 12 PM, employee FF indicated that they received their mail delivery for the day and the visit notes for clinical record # 21 had not been received. 4. The exit conference was conducted on 3/7/12 at 1:30 PM without receipt of the documents.	N 416		
N 446	410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3)	N 446		

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N 446	Continued From page 2 Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. This RULE is not met as evidenced by: Based on administrative document review and interview, the administrator failed to ensure all of the agency personnel received adequate education for 1 of 2 agency sites with the potential to affect all the patients served by the non-inserviced site. Findings include: 1. The untitled administrative document dated 1/26/12 stated, "Plan of correction for ISDH / CMS was gone over with [employee FF] and [employee EE] on 1/25/12. When asked [employee DD], if she and [employee F] were going to initiate the inservices as put in the POC [plan of correction] to start on 1/26/12, no answer was given. [employee DD] RN, administrator, nor [employee F, RN, DON [director of nursing] initiated inservices for 1/26/12. After collaborating with [employee EE] RN, Clinical Coordinator, it was decided that she should initiate inservices for POC. Due to the unavailability of administrator / DON they were not present for inservices so therefore no signatures will be obtained on inservice sign in sheets." The document was signed by employee EE and FF. 2. On 3/6/12 at 10:15 AM, employee FF presented administrative documents to evidence the agency personnel that provided patient care	N 446		

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N 446	Continued From page 3	N 446		

received adequate education. The administrative documents evidenced multiple inservices and education was presented and included:

A. The document titled "Inservice Attendance" dated January 26, 2012, from 1 P to 1:30 PM, stated, "Topic: In-service on Pain Management / documentation / meds with OASIS correlation and depression intervention, given by [employee EE]." The document indicated that employee II, the branch RN, was presented with the information on February 25, 2012, and stated, "Given by [employee FF] LPN, administrator." The document indicated Employee KK, the branch LPN, was presented with the information on February 27, 2012, and stated, "Given by [employee FF] LPN, administrator."

B. The document titled "Attendance" and dated 1/26/12, start time 1:40 PM and stop time 2:15 PM, stated, "Topic: In-service - DON will monitor 100 % of therapy cases Q [every] 14 days during supervisory visit completed by RN to assure therapist is showing up as scheduled. RN will provided care coordination with non skilled patients Q [every] 30 days to ensure patient is involved with POC [plan of care]. The RN will begin this with next 14 or 30 day supervisory visit. Patient handbooks to be left in home with each admission / readmission." The document failed to evidence the branch staff were presented with and received the same information.

C. The document titled "Attendance" dated 1/26/12, start time 2:30 PM and stop time 3 PM, stated, "Topic: In-service - Must document all telephone calls from patients and families before an order to hold services, must speak to families or patients for communication, such as requests, not home health aide." The in-service was

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N 446	Continued From page 4	N 446		

presented by employee EE. The document indicated that employee II, the branch RN was presented with the information on February 25, 2012, and stated, "Given by [employee FF] LPN, administrator." The document indicated that Employee KK, the branch LPN, was presented with the information on this sheet on February 27, 2012, and the document stated, "Given by [employee FF] LPN, administrator."

D. The document titled "In-service Attendance" dated 2/2/12, start time 10 AM and stop time 10:45 AM stated, "Topic: In-service - On policy of staging pressure ulcers, Braden scale, and comprehensive assessments." The in-service was presented by employee EE. The document indicated employee II, the branch RN, was presented with the information on February 25, 2012, and contained the statement, "Given by [employee FF] LPN, administrator." The document indicated that Employee KK, the branch LPN, was presented with the information on February 27, 2012, and contained the statement "Given by [employee FF] LPN, administrator."

E. The document titled "In-service Attendance" dated 2/3/12, start time documented was "8 - 10:50 AM" and stop time was documented as "1:45 PM - 4 PM" stated, "In serviced when aides picked up checks." The document stated, "Topic: What to report to the nurse: Not performing tasks that are not on CP [care plan] or performing tasks requested by pt [patient] / caregiver if not on CP [care plan]." The in-service was presented by employee EE. The document indicated that employee II, the branch RN, was presented with the information on February 25, 2012. The document failed to evidence employee KK was presented with the

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N 446	Continued From page 5 information. F. The document titled "Attendance" and dated 2/10/12, start time documented was 9:15 AM and stop time was documented as 9:45 AM, stated, "In-service - All pt's [patients] must have individualized POC [plan of care] that all required elements are completed. Given by [employee FF], LPN, administrator." The document indicated employee II, the branch RN, was presented with the information on February 25, 2012, and contained the statement, "Given by [employee FF] LPN, administrator." G. The document titled "In-service Attendance" dated 2/10/12, start time 9:50 AM and stop time 10 AM, stated, "Topic: In-service - staff to report any suspected problems which could affect patient care or safety to administrator / DON / ADON." The in-service was presented by employee FF. The document indicated employee II, the branch RN, was presented with the information on February 25, 2012, and contained the statement, "Given by [employee FF] LPN, administrator." The document indicated Employee KK, the branch LPN, was presented with the information on February 27, 2012, and contained the statement, "Given by [employee FF] LPN, administrator." H. The document titled "Attendance" dated 2/10/12, start time 2 PM and stop time 2:30 PM, stated, "Topic: In-service - Nurses to follow MD orders, copy of current 485 / plan of care and all new orders given to nurses." The in-service was presented by employee EE. The document indicated employee II, the branch RN, was presented with the information on February 25, 2012, and contained the statement, "Given by [employee FF] LPN, administrator." The	N 446		

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document indicated Employee KK, the branch LPN, was presented with the information on February 27, 2012, and contained the statement, "Given by [employee FF] LPN, administrator."

I. The document titled "In-service Attendance" dated 2/10/12, start time 3:45 PM and stop time 4:00 PM, stated, "Topic: In-service - Upon admission RN will speak with client / caregiver / MD to see if there are any outside entities providing care for the patient." The in-service was presented by employee EE. The document indicated that employee II, the branch RN, was presented with the information on February 25, 2012, and contained the statement, "Given by [employee FF] LPN, administrator."

J. The document titled "Attendance" dated 2/10/12, start time 4 PM and stop time 4:15 PM, stated, "Topic: In-service - On the highlighted attached." The attached document was titled "Plan of Correction Entry" and indicated the documented was printed from the Indiana State department of Health Survey Report System web site, the URL [uniform resource locator] was at the bottom of the document and was dated 2/12/12. The document was initialed by 8 staff. The sign in sheet documented the date as 2/10/12 and the document referenced was dated 2/12/12; therefore, it could not be determined the information was presented during the education period. The document indicated employee II, the branch RN, was presented with the information on February 25, 2012, and contained the statement, "Given by [employee FF] LPN, administrator." The document indicated that Employee KK, the branch LPN, was presented with the information on February 27, 2012, and contained the statement, "Given by [employee FF] LPN, administrator."

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K. The document titled "In-service" dated 2/10/12, 7 PM - 9 PM, stated, "Review: Company policies and Procedures, State and Federal Guidelines." Attendance was indicated by signature and included only employees EE, FF, and JJ, all administrative staff.

L. The document titled "CJ's Abundant Care, Skilled Nurse In - Service date: 2/29/12." The Topics included were 1) Role and function of the home Care Nurse. 2) RN Case Manager responsibilities for patient care and documentation of care provided. 3) Assignment Sheet. 4) CJ's scope of service. 5) Form for "Liability for Payment Addendum" - review this consent form. 6) Forms added to the admission packet to demonstrate best practice. 7) 485 / Plan of Care Worksheet. 8) Clinical Forms utilized to complete required processes. 9) Checklists. 10) Case Conference / Coordination of Care Form and Review of Process. 11) Review of Sentinel Events. 12) Competency Requirements to be implemented in next 1 - 2 months. The in-service was presented by the agency consultant. The administrative documents failed to evidence the branch employees were included and presented with the same information. The document evidenced only employees EE, FF, JJ, and LL (administrative staff and one RN) attended and received the information presented.

3. On March 6, 2012 at 11:45 AM, employee FF indicated she had accepted the position as administrator on February 9, 2012, and that employee EE had accepted the position as director of nursing on the same date. Employee FF indicated she had thought that employee F, the previous director of nursing and the full time

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N 446	Continued From page 8 registered nurse at the branch, was going to conduct the in - services and present the education material for the patient care staff of the branch. She indicated she discovered after employee F left employment on 2/21/11, the education was not completed for the branch personnel and she then educated employee II on 2/25/12 and employee KK on 2/27/12 during a home visit with patient # 21. She indicated the only personnel remaining from the branch and providing patient care were employees II and KK. 4. On March 7, 2012, at 10 AM, employee KK indicated the only time she was presented with in-service and educational material was while she was in the home of patient # 21 on February 27, 2012.	N 446		
{N 522}	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure treatments were provided as ordered on the plan of care in 1 of 3 clinical records reviewed of patients with skilled nursing services with the potential to affect all the agency's patients. (# 21) Findings Include: 1. Clinical record 21, start of care 10/27/11, evidenced a plan of care for the certification period 2/24/12 through 4/23/12 with orders for home health aide services. The clinical record evidenced a document titled "Recertification /	{N 522}		

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{N 522}	Continued From page 9 Follow-up Assessment" dated 2/23/11, completed by employee II, that indicated the patient had one wound located on the left heel and at the area of the assessment titled "Integumentary Status" was stated, "Turgor: Good, Other - L [left] heel, open wound." The area of the assessment titled "Wound Care" states, "Comments: Wound size of nickel, no active drainage / bleeding. Open, good skin blanching, around wound." The area of the assessment titled "Wound / Lesion" stated, "Location L [left] heel, Type: diabetic foot ulcer, Tunneling: no, Odor: no, Surrounding Skin: red and blanching, Edema: +1, Stoma: No, Appearance: no active drainage, yellow serous area, Drainage / Amount: none, Color: serosanguineous." The care summary stated, "Sore on L [left] heel size of nickel, no s + s [signs and symptoms] of infection. Dressed every 2 days per orders." A. The record evidenced a plan of care for the certification period 2/24/12 through 4/23/12 that identified the patient had a principle diagnosis of diabetes mellitus type II ICD -9-CM 250.00 and orders that stated, "SN [skilled nurse]: 2 times a day, 3 X [times] W [week] X 1 W, then 2 times a day, 7 X W X 8 W for: ... SN to perform assessment teach visit and vital signs daily, and prn. [if necessary] ... administer to patient insulin injections twice daily. Preset oral medications every other week and to monitor for medication compliance / effects. ... SN to change dressing to left heel every other day with sterile telfa, wrap with gauze wrap then ace bandage until client is seen by wound clinic in Connersville on 3/9/12. ... SN to monitor disease process of IDDM / MD / Cardiac. Perform glucometer check each visit and record. Observe skin for possible signs of breakdown, and feet for proper care." The clinical record failed to evidence an assessment	{N 522}		

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{N 522}	Continued From page 10 of the wound that included complete measurements and the appearance of the open wound bed. B. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/24/12 at 8:30 AM completed by employee KK. The note stated, "PO [oral] meds & [and] insulin given per MD orders ... dressing intact legs propped up on pillow." The skilled nurse note failed to evidence a complete skin assessment was completed that included an assessment of both of the patient's feet. The record failed to evidence an order for the nurse to administer oral medications. C. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/24/12 at 6:30 PM completed by employee KK. The note stated, "VS [vital signs] in am, pain assessed, OT [unknown] complete, insulin & PO meds [medications] given per MD orders, tolerate well, meal provided dressing intact LE [left extremity] propped up with pillows alert system @ [at] side." The skilled nurse note failed to evidence that a complete skin assessment was completed that included an assessment of both of the patient's feet. The record failed to evidence an order for the administration of oral medications. D. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/25/12 at 8:30 AM completed by employee KK. The skilled note indicated that the SN changed a wound dressing and stated, "Telfa, ABD pad, kerlix, ace bandage to LLE [left lower extremity]." The skilled nurse note failed to evidence that a complete skin assessment was completed that included an assessment of both of the patient's feet. E. The clinical record evidenced documents	{N 522}		

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{N 522}	Continued From page 11 titled "Nursing Visit Note" dated 2/25/12 at 6:30 PM completed by employee KK. The note stated, "VS done in am, pain assessed, OT [unknown] complete, insulin & PO meds given per MD orders, tolerate well, meal provided. Alert system @ side." The skilled nurse note failed to evidence that a complete skin assessment was completed that included an assessment of both of the patient's feet. The record failed to evidence an order for the administration of oral medications. F. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/26/12 at 6:30 PM completed by employee KK. The note stated, "VS done in am, pain assessed & charted, OT [unknown] complete, insulin & PO meds given per MD orders, tolerate well, meal provided, dressing is clean, dry, and intact will continue to monitor. Alert system @ side." The skilled nurse note failed to evidence that a complete skin assessment was completed that included an assessment of both of the patient's feet. The record failed to evidence an order for the administration of oral medications. G. On March 7, 2012 at 10:08 AM, employee KK, a licensed practical nurse, indicated there was not a plan of care in the home from the time she began providing services until one was delivered to the home on 2/27/12. She indicated she was providing the services to the patient from verbal orders given to her from employee F, the registered nurse in charge of the patient through 2/21/12. She indicated she was administering the patient's medications daily and was not checking the patient's feet at all during the nursing visits. She indicated she was not aware that checking the patient's feet was a task to be completed by her during the skilled nurse visits; she indicated	{N 522}		

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{N 522}	Continued From page 12 the patient always had slippers and stockings on both feet and that she had not removed them to assess the skin on the patients' feet. 2. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services." 3. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician." 4. The policy titled "Skilled Nursing Services" states "Skilled nursing services will be provided by a Registered nurse or a Licensed Practical / Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders).	{N 522}		
N 537	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure treatments were provided as ordered on the plan of care in 1 of 3 clinical records reviewed of patients with skilled nursing services with the potential to affect all the agency's patients. (# 21)	N 537		

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CJ'S ABUNDANT CARE	523 W PLUM ST CHESTERFIELD, IN 46017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 537	Continued From page 13 Findings Include: 1. Clinical record 21, start of care 10/27/11, evidenced a plan of care for the certification period 2/24/12 through 4/23/12 with orders for home health aide services. The clinical record evidenced a document titled "Recertification / Follow-up Assessment" dated 2/23/11, completed by employee II, that indicated the patient had one wound located on the left heel and at the area of the assessment titled "Integumentary Status" was stated, "Turgor: Good, Other - L [left] heel, open wound." The area of the assessment titled "Wound Care" states, "Comments: Wound size of nickel, no active drainage / bleeding. Open, good skin blanching, around wound." The area of the assessment titled "Wound / Lesion" stated, "Location L [left] heel, Type: diabetic foot ulcer, Tunneling: no, Odor: no, Surrounding Skin: red and blanching, Edema: +1, Stoma: No, Appearance: no active drainage, yellow serous area, Drainage / Amount: none, Color: serosanguineous." The care summary stated, "Sore on L [left] heel size of nickel, no s + s [signs and symptoms] of infection. Dressed every 2 days per orders." A. The record evidenced a plan of care for the certification period 2/24/12 through 4/23/12 that identified the patient had a principle diagnosis of diabetes mellitus type II ICD -9-CM 250.00 and orders that stated, "SN [skilled nurse]: 2 times a day, 3 X [times] W [week] X 1 W, then 2 times a day, 7 X W X 8 W for: ... SN to perform assessment teach visit and vital signs daily, and prn. [if necessary] ... administer to patient insulin injections twice daily. Preset oral medications every other week and to monitor for medication compliance / effects. ... SN to change dressing to	N 537		

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N 537	Continued From page 14 left heel every other day with sterile telfa, wrap with gauze wrap then ace bandage until client is seen by wound clinic in Connersville on 3/9/12. ... SN to monitor disease process of IDDM / MD / Cardiac. Perform glucometer check each visit and record. Observe skin for possible signs of breakdown, and feet for proper care." The clinical record failed to evidence an assessment of the wound that included complete measurements and the appearance of the open wound bed. B. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/24/12 at 8:30 AM completed by employee KK. The note stated, "PO [oral] meds & [and] insulin given per MD orders ... dressing intact legs propped up on pillow." The skilled nurse note failed to evidence a complete skin assessment was completed that included an assessment of both of the patient's feet. The record failed to evidence an order for the nurse to administer oral medications. C. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/24/12 at 6:30 PM completed by employee KK. The note stated, "VS [vital signs] in am, pain assessed, OT [unknown] complete, insulin & PO meds [medications] given per MD orders, tolerate well, meal provided dressing intact LE [left extremity] propped up with pillows alert system @ [at] side." The skilled nurse note failed to evidence that a complete skin assessment was completed that included an assessment of both of the patient's feet. The record failed to evidence an order for the administration of oral medications. D. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/25/12 at 8:30 AM completed by employee KK. The skilled note	N 537		

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N 537	Continued From page 15 indicated that the SN changed a wound dressing and stated, "Telfa, ABD pad, kerlix, ace bandage to LLE [left lower extremity]." The skilled nurse note failed to evidence that a complete skin assessment was completed that included an assessment of both of the patient's feet. E. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/25/12 at 6:30 PM completed by employee KK. The note stated, "VS done in am, pain assessed, OT [unknown] complete, insulin & PO meds given per MD orders, tolerate well, meal provided. Alert system @ side." The skilled nurse note failed to evidence that a complete skin assessment was completed that included an assessment of both of the patient's feet. The record failed to evidence an order for the administration of oral medications. F. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/26/12 at 6:30 PM completed by employee KK. The note stated, "VS done in am, pain assessed & charted, OT [unknown] complete, insulin & PO meds given per MD orders, tolerate well, meal provided, dressing is clean, dry, and intact will continue to monitor. Alert system @ side." The skilled nurse note failed to evidence that a complete skin assessment was completed that included an assessment of both of the patient's feet. The record failed to evidence an order for the administration of oral medications. G. On March 7, 2012 at 10:08 AM, employee KK, a licensed practical nurse, indicated there was not a plan of care in the home from the time she began providing services until one was delivered to the home on 2/27/12. She indicated she was providing the services to the patient from	N 537		

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N 537	Continued From page 16 verbal orders given to her from employee F, the registered nurse in charge of the patient through 2/21/12. She indicated she was administering the patient's medications daily and was not checking the patient's feet at all during the nursing visits. She indicated she was not aware that checking the patient's feet was a task to be completed by her during the skilled nurse visits; she indicated the patient always had slippers and stockings on both feet and that she had not removed them to assess the skin on the patients' feet. 2. Agency policy #C-580, not dated, titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the client's physician ... SPECIAL INSTRUCTIONS 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services." 3. Agency policy #C-635, not dated, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to clients must be ordered by a physician." 4. The policy titled "Skilled Nursing Services" states "Skilled nursing services will be provided by a Registered nurse or a Licensed Practical / Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders).	N 537		
{N 545}	410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:	{N 545}		

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{N 545}	Continued From page 17 (F) Coordinate services. This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse provided the licensed practical nurse with the physician's orders so that the patient's care could be coordinated in 1 of 3 clinical records reviewed of patients receiving skilled nursing services with the potential to affect all the agency's patients. (# 21) Findings Include: 1. Clinical record 21, start of care 10/27/11, evidenced a plan of care for the certification period 2/24/12 through 4/23/12 with orders for home health aide services. The clinical record evidenced a document titled "Recertification / Follow-up Assessment" dated 2/23/11, completed by employee II, that indicated the patient had one wound located on the left heel and at the area of the assessment titled "Integumentary Status" was stated, "Turgor: Good, Other - L [left] heel, open wound." The area of the assessment titled "Wound Care" states, "Comments: Wound size of nickel, no active drainage / bleeding. Open, good skin blanching, around wound." The area of the assessment titled "Wound / Lesion" stated, "Location L [left] heel, Type: diabetic foot ulcer, Tunneling: no, Odor: no, Surrounding Skin: red and blanching, Edema: +1, Stoma: No, Appearance: no active drainage, yellow serous area, Drainage / Amount: none, Color: serosanguineous." The care summary stated, "Sore on L [left] heel size of nickel, no s + s [signs and symptoms] of infection. Dressed every 2 days per orders." A. The record evidenced a plan of care for	{N 545}		

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{N 545}	Continued From page 18	{N 545}		

the certification period 2/24/12 through 4/23/12 that identified the patient had a principle diagnosis of diabetes mellitus type II ICD -9-CM 250.00 and orders that stated, "SN [skilled nurse]: 2 times a day, 3 X [times] W [week] X 1 W, then 2 times a day, 7 X W X 8 W for: ... SN to perform assessment teach visit and vital signs daily, and prn. [if necessary] ... administer to patient insulin injections twice daily. Preset oral medications every other week and to monitor for medication compliance / effects. ... SN to change dressing to left heel every other day with sterile telfa, wrap with gauze wrap then ace bandage until client is seen by wound clinic in Connersville on 3/9/12. ... SN to monitor disease process of IDDM / MD / Cardiac. Perform glucometer check each visit and record. Observe skin for possible signs of breakdown, and feet for proper care." The clinical record failed to evidence an assessment of the wound that included complete measurements and the appearance of the open wound bed.

B. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/24/12 at 8:30 AM completed by employee KK. The note stated, "PO [oral] meds & [and] insulin given per MD orders ... dressing intact legs propped up on pillow." The skilled nurse note failed to evidence a complete skin assessment was completed that included an assessment of both of the patient's feet. The record failed to evidence an order for the nurse to administer oral medications.

C. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/24/12 at 6:30 PM completed by employee KK. The note stated, "VS [vital signs] in am, pain assessed, OT [unknown] complete, insulin & PO meds [medications] given per MD orders, tolerate well,

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{N 545}	Continued From page 19 meal provided dressing intact LE [left extremity] propped up with pillows alert system @ [at] side." The skilled nurse note failed to evidence that a complete skin assessment was completed that included an assessment of both of the patient's feet. The record failed to evidence an order for the administration of oral medications. D. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/25/12 at 8:30 AM completed by employee KK. The skilled note indicated that the SN changed a wound dressing and stated, "Telfa, ABD pad, kerlix, ace bandage to LLE [left lower extremity]." The skilled nurse note failed to evidence that a complete skin assessment was completed that included an assessment of both of the patient's feet. E. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/25/12 at 6:30 PM completed by employee KK. The note stated, "VS done in am, pain assessed, OT [unknown] complete, insulin & PO meds given per MD orders, tolerate well, meal provided. Alert system @ side." The skilled nurse note failed to evidence that a complete skin assessment was completed that included an assessment of both of the patient's feet. The record failed to evidence an order for the administration of oral medications. F. The clinical record evidenced documents titled "Nursing Visit Note" dated 2/26/12 at 6:30 PM completed by employee KK. The note stated, "VS done in am, pain assessed & charted, OT [unknown] complete, insulin & PO meds given per MD orders, tolerate well, meal provided, dressing is clean, dry, and intact will continue to monitor. Alert system @ side." The skilled nurse note failed to evidence that a complete skin	{N 545}		

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{N 545}	Continued From page 20 assessment was completed that included an assessment of both of the patient's feet. The record failed to evidence an order for the administration of oral medications. G. On March 7, 2012 at 10:08 AM, employee KK, a licensed practical nurse, indicated there was not a plan of care in the home from the time she began providing services until one was delivered to the home on 2/27/12. She indicated she was providing the services to the patient from verbal orders given to her from employee F, the registered nurse in charge of the patient through 2/21/12. She indicated she was administering the patient's medications daily and was not checking the patient's feet at all during the nursing visits. She indicated she was not aware that checking the patient's feet was a task to be completed by her during the skilled nurse visits; she indicated the patient always had slippers and stockings on both feet and that she had not removed them to assess the skin on the patients' feet. 2. The policy titled "Skilled Nursing Services" states "Skilled nursing services will be provided by a Registered nurse or a Licensed Practical / Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care (physician's orders). 3. On March 6, 2012, at 4:22 PM, employee FF indicated there was not an approved agency policy or procedure for the communication between the agency personnel that staff that provided patient care.	{N 545}		
N 608	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing	N 608		

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N 608	Continued From page 21 pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure all clinical records could be maintained if records sent in the mail were lost for 1 of 5 records reviewed (#21) with the potential to affect all patient records that are mailed. Findings include: 1. Clinical record # 21 failed to evidence care was provided to the patient from February 27, 2012, through March 4, 2012. 2. On 3/6/12 at 11:45 AM, employee FF indicated the nurse visit notes for the care provided on February 27 through March 4, 2012, for patient # 21, were not available and had been placed into the mail. They expected the notes to be delivered by the United States postal service on Wednesday March 7, 2012. 3. On 4:30 PM on 3/6/12, employee FF indicated	N 608		

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N 608	Continued From page 22 the agency did not have a policy or procedure to protect and identify what should be done when chart documents were placed in the US mail and they could become lost. 4. On 3/7/12 at 12 PM, employee FF indicated they received their mail delivery for the day and the visit notes for clinical record # 21 had not been received.	N 608		
N 614	410 IAC 17-15-1(c) Clinical Records Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service. This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure all clinical records were safeguarded against loss for 1 of 5 records reviewed (#21) with the potential to affect all patient records that are mailed. Findings include: 1. Clinical record # 21 failed to evidence care was provided to the patient from February 27, 2012, through March 4, 2012.	N 614		

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N 614	Continued From page 23 2. On 3/6/12 at 11:45 AM, employee FF indicated the nurse visit notes for the care provided on February 27 through March 4, 2012, for patient # 21, were not available and had been placed into the mail. They expected the notes to be delivered by the United States postal service on Wednesday March 7, 2012. 3. On 4:30 PM on 3/6/12, employee FF indicated the agency did not have a policy or procedure to protect and identify what should be done when chart documents were placed in the US mail and they could become lost. 4. On 3/7/12 at 12 PM, employee FF indicated they received their mail delivery for the day and the visit notes for clinical record # 21 had not been received.	N 614		